No. 2
-2-43
17.39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

35365

State File No.

Registration District No. 237 Primary Registration District No. 4353 Registrar's No. 35

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County New Madrid.
(b) City or town Gideon, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County 000
(c) City or town St. Louis City. 17
(If outside city or town limits, write "RURAL") 9
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sidney Childres Eaton.

3. (b) If veteran, name war No.

3. (c) Social Security No. 486-16-6269

4. Sex 0 male.

5. Color or race white

6. (a) Single, widowed, married, divorced 3 divorced

6. (b) Name of husband or wife Do not know.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 18th. (Day) 1887 (Year)

8. AGE: Years 56 Months 6 Days 1 If less than one day hr. min.

9. Birthplace Marion, Kentucky. (City, town, or county) (State or foreign country)

10. Usual occupation box plant.

11. Industry or business lumber

FATHER
12. Name John Eaton.
13. Birthplace Nashville, Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucinda Norton.
15. Birthplace Nashville, Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant John W Eaton
(b) Address 4055 A. Chouteau. St. Louis, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 22. 43 (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston Mo.

18. (a) Signature of funeral director Day Funeral Home
(b) Address Malden, Mo.

19. (a) Sept 22-43 (Date received local registrar) (b) Lucinda Mason (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19th.
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from Sept 19-43, 19 to Sept 19, 1943
that I last saw him alive on Sept 19/43, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Sleeve fractured

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy no

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address Gideon Mo Date signed 9/20/43

(Licensed Embalmer's Statement on Reverse Side)

530

RECEIVED
District Health Office No. 2
District File Number 1043-13
Date Filed 10-29-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2
2-43
17-39
X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)

In this community (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sidney Children Eaton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19 year 194 hour 5150 minute P.M.

21. I hereby certify that I attended the deceased from ✓ ✓, 19, to ✓ ✓, 19; that I last saw h ✓ alive on ✓, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Fractured Skull over Left eye Hit in Middle

Due to and top of head Two bruised place on

Due to Right Shoulder Hit by a Walking Cane

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations

Of autopsy No.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Homicide

(b) Date of occurrence Sept 19-1943

(c) Where did injury occur? New Madrid, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? no (e) Means of injury 2

23. Signature Leo Hedgepeth Deputy Coroner (M. D. or other)

Address New Madrid, Mo. Date signed 9/21-43

(Licensed Embalmer's Statement on Reverse Side)

35365

RECEIVED
District Health Office No. 2,
District File Number 1043-1362
Date Filed 10-29-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Leo Hedgpeth

Licensed Embalmer No. 3803

P. O. Address New Madrid, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.